Health Department and
Community Health Center

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Executive Director

Immunization Program
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Consent by Proxy Form for Treatment of a Minor

I, _____, parent of _____, hereby grant
(parent's name) (child's name)

_____ the authority to consent to the administration of vaccines at the
(temporary guardian's name)

Lake County Health Department Immunization Program.

This temporary authority is for the following date(s) of service:

From: ____/___/_____ Month/Day/Year To: ____/___/_____ Month/Day/Year (maximum is 1 year)

This temporary authority expires one year after the date that this form is signed, unless the parent or legal guardian provides a shorter time frame according to the dates listed above. The parent may revoke this Consent by Proxy, in writing, at any time.

_____ _____
Child's Name Child's Date of Birth

_____ _____
Parent or Guardian's Name Relationship to Child

_____ _____
Parent or Guardian's Address Phone Number

_____ _____
Temporary Guardian's Name Relationship to Child

_____ _____
Temporary Guardian's Address Phone Number

The temporary guardian listed above is authorized to consent to treatment with all recommended vaccines except _____.
(list any exceptions here)

_____ _____ _____
Parent or Legal Guardian's Printed Name Parent or Legal Guardian's Signature Date